COMMUNITY HEALTH PLAN of Washington

DEPARTMENT:	Utilization Management (UM)	**ORIGINAL APPROVAL:**	07/13/2000
POLICY #:	UM.204	**LAST APPROVAL:**	10/14/2009
TITLE:	Denial Process		
APPROVED BY:	Medical Management Leadership Team		
DEPENDENCIES:	Utilization Management Policy UM.203: Prior Authorization (PA) Utilization Management Policy UM.205: Timeliness of UM Decision-Making Utilization Management Policy UM.214: Discussing a Denial with a Reviewer 2009 UM Program Description		

PURPOSE

The purpose of this policy is to define which staff are authorized to issue denials for service requests.

POLICY

Only approved Medical Management staff (Medical Directors, Clinical Pharmacists, and Associate Clinical Director) shall issue a decision for non-certification or denial of services or equipment for both medical and behavioral health requests.

MEDICAL NECESSITY & APPROPRIATENESS

Medical necessity and appropriateness are defined as those services determined by the Health Plan or its designated representative to be:

- Preventive, diagnostic, and/or therapeutic in nature;
- Specifically related to the condition which is being treated or evaluated;
- Rendered in the least costly medically appropriate setting (e.g., inpatient, outpatient, ambulatory surgery center, office), based on the severity of illness and intensity of service required;
- Not solely for the member's convenience or that of his or her physician; and
- Is supported by evidence-based medicine.

TYPES OF DENIAL REVIEWS

Depending upon the type of service or equipment requested the following types of denial reviews may be conducted.

Clinical Review for "Not a Covered Benefit" (Benefit Override)

For lines of business with benefit exclusions or benefit limits, it is considered a contract exclusion if the requested service is not a benefit for any member enrolled in that line of business. In some cases, however, benefit exceptions are made in the **Second Level Review**. These reviews are categorized

as "clinical reviews for not a covered benefit." Requests that fall into this category must be reviewed by the Medical Director or his/her delegate for approval or denial.

Medical Review for "Medical Necessity"

Requests processed at **First Level Review** that do not meet "medical necessity" criteria or have been determined, after physician review, to be "not medically necessary" are denied as "Not Medically Necessary". Only the Chief Medical Officer, Medical Directors, Associate Clinical Director, and Clinical Pharmacists shall make medical necessity denials.

Authorization requests are processed in a timely fashion, as described in policy UM.205: Timeliness of UM Decision-Making.

FIRST LEVEL REVIEW

Authorization requests which require clinical or medical necessity review are first reviewed by the appropriate Care Management staff. After review, Care Management shall clarify information, as needed, and confirm the amount and duration of the requested service with the submitting provider. First Level Review staff review the case according to policy UM.203: Prior Authorization and Precertification using Milliman ® Guidelines or CHP Internal Criteria, as appropriate. If the reviewer cannot approve the request based on comparison of supplied documentation to the appropriate guideline or criteria, the case is sent to the Medical Director for physician review.

First Level Review Staff

The following employees shall be approved as First Level Review staff with the authority to approve services that meet the Health Plan guidelines for approval:

- The Case/Disease Management Manager is a registered nurse.
- The Utilization Management Manager is a registered nurse.
- The Care Coordination/Behavioral Health Manager is a licensed independent clinical social worker, authorized by the State of Washington as an approved supervisor.
- The Utilization Review Nurses are registered nurses and licensed practical nurses.
- The Utilization Management Coordinators are non-clinical staff who are accountable for conducting reviews of requests for medical and behavioral health services that exactly match the guidelines for approval under the direction and oversight of a licensed clinical staff member.
- The Case Managers, Precertification Nurses, and Concurrent Review Nurses are registered nurses.
- The MSW Care Coordinators are licensed clinical social workers (LASW or LICSW.)
- Other Care Management staff at the direction and under the direct supervision of licensed staff from the above list.
- All Second Level approved reviewers may make First Level Review decisions.

SECOND LEVEL REVIEW

If the service request does not meet approved guidelines or criteria, or if there are no criteria available for the service or condition under review, the request is forwarded to a Medical Director, Clinical Pharmacist or Associate Clinical Director, as appropriate, for Second Level Review. CHP has a written job description with qualifications for practitioners who review denials of care based on medical necessity.

CHP shall require practitioners who perform medical necessity denials to have education, training and professional experience.

Second Level Review Functions

The Second Level Reviewer, in addition to considering case-specific details, shall:

- Perform an assessment of the local delivery system to determine if there are relevant geographic and/or access issues that must be taken into account.
- Determine if the procedure is cosmetic, experimental or investigational.
- Issue a non-covered service or medical-necessity denial as appropriate.

The Second Level Reviewer shall consider requests based on the application of evidence-based criteria, best clinical practices, review of the medical literature, and other sources such as Milliman Care Guidelines®, Hayes, Inc., or consultation with a board certified specialist. External review by a peer review organization will be arranged as necessary.

Approvals & Denials

The Second Level Reviewer may approve a request, approve a portion of a request (partial denial), or issue a clinical or medical necessity denial of a request.

The Second Level Reviewer may contact the submitting provider directly or may request that the First Level Reviewer contact the submitting provider to obtain additional information, if necessary. If the requested information is not submitted **within two business days** of the request, then a medical-necessity denial is issued by the Second Level Reviewer.

ENROLLEE AND PROVIDER NOTIFICATION

When a denial decision is made, including a "partial denial" (a denial of authorization request or authorization of a service in an amount, duration or scope that is less than requested), a written notice in easily understandable language is mailed to the enrollee that includes the following:

- A clear statement of denial action being taken by the Plan.
- The specific reason for the denial in that includes the Second Level Reviewer's rationale for denial and the mechanism to be used by members and providers to contact the Second Level Reviewers to discuss the denial.
- A reference to the benefit provision, guideline, protocol or similar criterion on which the denial decision was based.

- Notification that, upon request, the member can obtain a copy of the actual benefit provision, guideline, protocol or other similar criteria on which the denial decision was based.
- A description of appeal rights (including the right to submit written comments, documents, or other information relevant to the appeal), an explanation of the appeal process (including the right to member representation and time frames for deciding appeals), and a description of the expedited appeal process for urgent pre-service or urgent concurrent denials.

The PCP, ordering provider and treating provider shall receive a faxed copy of the member letter and all the above listed supportive documents as notification of the decision.

Timeliness of decision-making and notification of provider and enrollee after non-certification decisions is defined in policy UM.205: Timeliness of UM Decision-Making.

Practitioner Inquiries

CHP provides practitioners with the opportunity to discuss any medical necessity decision (both behavioral and non-behavioral) with a physician or other appropriate reviewer.

Practitioners are encouraged to speak directly with the Reviewer in order to answer their questions. Calls usually enter CHP via the Customer Service Department at 1-800-440-1561; however, UM.214 Discussing a Denial with a Reviewer is to be used by all departments.

The discussion may result in the overturning of the denial, resulting in an approval of the service.

Denial Discussions with Providers

For all lines of business, in most cases, the original decision-maker provides discussion of denial rationale. If original decision-maker is not available, another second level reviewer will provide discussion of denial rationale. However, at no time will the physician discussing the case overturn the coverage determination made by his/her MD supervisor.

If the discussion does not result in the approval of the service, the provider is given the option to appeal on behalf of the enrollee and the applicable Grievance and Appeal process is given. If the provider desires, an appeal will be started at this time.

If a provider calls or otherwise notifies the Plan more than 30 days after the denial decision, s/he is given the option to appeal on behalf of the enrollee and the applicable Grievance and Appeal process is given. If the provider desires, an appeal will be started at this time.

Tracking Decisions

Information related to denial rates, timeliness of UM decision-making, and information to support audits that monitor consistency of UM decision-making/application of clinical criteria shall be available through the "Reports" function of the Medical Management System (JIVA).

LIST OF APPENDICES

None

CITATIONS & REFERENCES

CFR	
WAC	
RCW	
CONTRACT CITATION	☒ HO/SCHIP 9.1, 9.2 (HO, SCHIP, S-MED, BH+) ☒ BH (BHS, BH-SUB, BH-HCTC) ☒ MA ☒ GA-U 3(5)(D), 4(A), 4(B), 7(C)
OTHER REQUIREMENTS	– HRSA 438.210C, 438.236D, 438.404B, 438.406B
NCQA ELEMENTS	2010 UM 7.A.1, UM 7.C, UM 7.D

REVISION HISTORY

REVISION DATE	REVISION DESCRIPTION	REVISION MADE BY
07/13/2000	Original	UM/CM Manager
09/28/2005		UM Manager
10/25/2006		Georgette Cortel
11/13/2007	Formatting; clarification re timeliness, MD reconsideration of denial	Georgette Cortel
11/2/2008	Revision to modify items going to medical reviewers	Tracey Gunderson
4/14/09	Clarification of Physician/ Psychologist/Psychiatrist and Clinical Pharmacists as Second Level Reviewers. Clarification of roles for review.	Sandra Hewett
8-14-09	Revised for NCQA Compliance	Marcia Bush Michael Hays Christa Lilienthal Sauni Polu
10/14/09	No change	Verni Jogaratnam
11/09/2009	Moved to new template; edited for style & clarity; request cited denial letter for appendix	Jennifer Carlisle